TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gregory P. Ennis, M.D.

Respondent Name
Hartford Casualty Insurance Company

MFDR Tracking Number
M4-17-0427-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The email or facsimile receipts contain the electronic file name which contents are included in this packet … EcCare submits this mail log, fax receipt, or email read receipt as evidence of timely submission of the specific bill herein disputed."

Amount in Dispute: $1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill was processed in our system on DCN 2016266F8103001 (case # 00GB1628104992), and cleared a payment of $1000.00 on 10/11/16 (check #0131641251)."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 23, 2016	Designated Doctor Examination	$1,000.00	$1,000.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the requirements for a complete medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submission of a medical bill.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services performed from March 1, 2008 until September 1, 2016.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is Gregory P. Ennis, M.D. entitled to reimbursement for the services in question?

Findings

1. Gregory P. Ennis, M.D. is seeking reimbursement of $1,000.00 for a designated doctor examination to determine maximum medical improvement, impairment rating, and the ability of the injured employee to return to work performed on February 23, 2016.

   Hartford Casualty Insurance Company (Hartford) denied disputed services with claim adjustment reason code 29 – "TIME LIMIT FOR FILING HAS EXPIRED." 28 Texas Administrative Code §133.20 requires that the health care provider submit a medical bill not later than the 95th day after the date of service. Review of the submitted information finds a fax confirmation that supports a bill for the services in question were submitted on February 23, 2016. Further, Hartford failed to maintain this denial in its response. The insurance carrier's denial for this reason is not supported.

2. In its position statement, Gallagher Bassett, on behalf of Hartford, stated, "This bill was processed in our system on DCN 2016266F8103001 (case # 00GB1628104992), and cleared a payment of $1000.00 on 10/11/16 (check #0131641251)." No explanation of benefits was received to support that payment was made on this dispute. Therefore, the services in question will be reviewed in accordance with 28 Texas Administrative Code §134.204.

   Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. Ennis performed an evaluation of Maximum Medical Improvement. Therefore, the reimbursement for this examination is $350.00.

   28 Texas Administrative Code §134.204(j)(4)(D) states that, "(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150."Review of the submitted documentation finds that Dr. Ennis performed an impairment rating evaluation of a right incarcerated hernia. Therefore, the reimbursement for this examination is $150.00.

   Per 28 Texas Administrative Code §134.204(k),

   > The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports …

   The submitted documentation indicates that the Designated Doctor performed an examination to determine the ability of the injured employee to return to work. Therefore, the reimbursement for this examination is $500.00.

   The total reimbursement for the disputed services is $1,000.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,000.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,000.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.